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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

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IS11-29 **Diagnostic Services (Important)** **Effective Date: October 15, 1999**

Ralf J. Salke
Regional Manager

Gary H. Campbell, DO
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

R. Dale Riley, Director
Division of Offender
Rehabilitation Services

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I. **PURPOSE:** This procedure provides laboratory and diagnostic services in a timely manner. Those services not provided on-site may be obtained from a local or contracted provider.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A: **CLIA:** Clinical Laboratory Improvement Amendment. Federal requirement of medical providers to delineate what types and kinds of laboratory testing is available in their facility.

III. **PROCEDURES:**

A. Diagnostic services completed on site should be registered, accredited, or otherwise meet state and federal laws.

B. At sites where radiology examinations are completed, monthly exposure levels will be monitored through dosimetry, on all staff involved in completing radiology procedures.

C. A written order for diagnostic or laboratory tests should be provided as indicated by the physician or statutes.

D. Designated health care staff should perform, document, and report results of those tests that are performed on-site to the physician ordering the test.

E. Laboratory tests and diagnostic studies not available at the institution should be completed by a local or contracted provider.

1. Designated health care staff should prepare requisitions for off-site testing.

2. When the procedure dictates that the offender must go off-site, these off-site tests should be scheduled by completing the approved referral forms and arranging for offender transportation with the chief of custody.

3. Laboratory specimens should be obtained, labeled, and transported according to local provider requirements.

4. Off-site diagnostic testing should be entered on the Off-Site Referral Log (Attachment A) to permit tracking of receipt of results.

F. The reports for physician review should be paper clipped to the front of the applicable medical record and placed in a designated area. Physician review should be indicated by the physician initialing and dating the report.

G. After physician review, orders for treatment should be initiated by the physician and transcribed by nursing staff.

H. Reviewed diagnostic reports should be inserted in the Medical Record or placed in MARS.

I. The health services administrator should apply for certification of waiver from Health Care Financing Administration in accordance with Clinical Laboratory Improvement Amendment (CLIA) (Attachment B) requirements by completing and sending the CLIA form to : Health Care Financing Administration Clinical Laboratory Improvement Amendments Program, P.O. Box 26679, Baltimore, MD 21207-0479.

J. The following diagnostic services may be available on-site:

1. multiple-test-dipstick urinalysis
2. finger stick blood glucose testing
3. hand-held peak flow meter
4. occult stool cards and developer
5. electrocardiogram
6. refractions
7. non-invasive table top radiology procedures.

IV. ATTACHMENTS:

A. 931-4175 Off-Site Referral Log
B. Clinical Laboratory Improvement Amendments of 1988 (CLIA) Form

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V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 1997. P-29

VI. HISTORY: Previously covered under IS11-28.1 in the Missouri Department of Corrections Institutional Policy and Procedure Manual. Original Rule Effective: August 15, 1998

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

OFF-SITE REFERRAL LOG

OFFENDER NAME	DOC NUMBER	ORDER DATE	PHYSICIAN	REASON	DATE CONSULT FORM APPROVED	DATE SCHEDULED	DATE CANCEL/ REASON	DATE RESCHED-ULED	DATE COMPLETED	FOLLOW UP REQUESTED

MO 931-4175 (2-99)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0581

CLINICAL LABORATORY APPLICATION
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

I. GENERAL INFORMATION

Please check any preprinted information on this part of the form and make any necessary corrections. Complete the rest of the form according to the directions.

CLIA IDENTIFICATION NUMBER		FEDERAL TAX IDENTIFICATION NUMBER	
LABORATORY NAME		TELEPHONE NO. *(include area code)*	
LABORATORY ADDRESS *(number, street)*	CITY	STATE	ZIP
MAILING ADDRESS *(if different from above)*	CITY	STATE	ZIP

NAME OF DIRECTOR *(please print or type)*

last *first* *MI*

dicate changes below as needed.

ORATORY NAME		TELEPHONE NO. *(include area code)*	
BORATORY ADDRESS *(number, street)*	CITY	STATE	ZIP
MAILING ADDRESS *(if different from above)*	CITY	STATE	ZIP

NAME OF DIRECTOR *(please print or type)*

last *first* *MI*

II. APPLICATION IS FOR: *(check one box)*

- ☐ Certificate
- ☐ **Certificate of Waiver
- ☐ Certificate of Accreditation
- ☐ Renewal of Certificate
- ☐ Renewal of Certificate of Waiver
- ☐ Renewal of Certificate of Accreditation

**IF YOU CONDUCT ONLY THE FOLLOWING WAIVED TESTS *(ONE OR MORE)*, YOU MAY APPLY FOR A CERTIFICATE OF WAIVER:

- Dipstick or tablet reagent urinalysis (nonautomated) for:
  - -bilirubin
  - -glucose
  - -hemoglobin
  - -ketone
  - -leukocytes
  - -nitrite
  - -protein
  - -pH
  - specific gravity
  - -urobilinogen
  - ecal occult blood
  - vulation test-visual color comparison tests for human uteinizing hormone
- Urine pregnancy test-visual color comparison tests
- Erythrocyte sedimentation rate (nonautomated)
- Hemoglobin-copper sulfate (nonautomated)
- Blood glucose, by glucose monitoring devices cleared by the FDA specifically for home use; and
- Spun microhematocrit

If applying for a **certificate of waiver**, complete all sections of this form except section VIII.

III. TYPE OF LABORATORY *(check the one most descriptive of facility type)*

___ 01 Ambulatory Surgery Center
___ 02 Community Clinic
___ Comp. Outpatient Rehab. Facility
___ Ancillary Testing Site in Health Care Facility
___ 05 End Stage Renal Disease Dialysis Facility
___ 06 Health Fair
___ 07 Health Main. Organization
___ 08 Home Health Agency
___ 09 Hospice
___ 10 Hospital
___ 11 Independent
___ 12 Industrial
___ 13 Insurance
___ 14 Intermediate Care Fac. for Mentally Retarded
___ 15 Mobile Unit
___ 16 Pharmacy
___ 17 School/Student Health Service
___ 18 Skilled Nursing Facility/Nursing Facility
___ 19 Physician Office
___ 20 Other Practitioner *(specify)* _____
___ 21 Tissue Bank/Repositories
___ 22 Blood Banks
___ 23 Other *(specify)* _____

Was this laboratory previously regulated under the Federal Medicare/Medicaid and/or CLIA programs? (Regulations published March 14, 1990 at 55 FR 9538) ☐ Yes ☐ No

IV. HOURS OF ROUTINE OPERATION

List days and hours during which laboratory testing is performed

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM: AM							
PM							
TO: AM							
PM							

(For multiple sites attach the additional information using the same format)

V. MULTIPLE SITES

Are you applying for one certificate for multiple sites? ☐ No *If no*, go to next section.
☐ Yes *If yes*, total number of sites _____ and complete appropriate section below.

Identify which of the following exception requirements applies to your laboratory operation.

Is this a non-profit or Federal, State or local government laboratory engaged in limited *(e.g., few types of tests)* public health testing and filing for a single certificate for multiple sites? ☐ Yes ☐ No *If yes*, list name, address and tests performed for each site below.

Is this a hospital with several laboratories at the same street address and under common direction that is filing for a single certificate for these locations? ☐ Yes ☐ No *If yes*, list name or department, location within hospital and specialty/subspecialty areas for each site below.

If additional space is needed, check here ____ and attach the additional information using the same format.

NAME AND ADDRESS / LOCATION	TESTS PERFORMED / SPECIALTY / SUBSPECIALTY
Name of laboratory or hospital department	
Address/location (number, street, location if applicable)	
City, State, ZIP / Telephone No. ( )	
Name of laboratory or hospital department	
Address/location (number, street, location if applicable)	
City, State, ZIP / Telephone No. ( )	
Name of laboratory or hospital department	
Address/location (number, street, location if applicable)	
City, State, ZIP / Telephone No. ( )	

VI. ACCREDITATION INFORMATION

Is your laboratory presently accredited by any private nonprofit organization ..... ☐ Yes ☐ No

If yes, check all that apply:

Accredited by:

- ☐ JCAHO
- ☐ AOA
- ☐ AABB
- ☐ CAP
- ☐ COLA
- ☐ ASC
- ☐ ASHI
- ☐ Other *(specify)* _____

VII. WAIVED TESTING

Indicate total annual test volume for all waived tests performed. _____

VIII. NONWAIVED TESTING

If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, include information for all sites.

Place a check (√) in the box preceding each specialty/subspecialty in which the laboratory performs testing. Enter the test volume for the previous calendar year for each specialty. If you are a new laboratory or have added new specialties/subspecialties, for test volume, enter your estimated annual test volume. Do not include testing not subject to CLIA, waived tests, or tests run for quality control, quality assurance or proficiency testing when estimating total volume. Each profile, panel or group of tests usually performed simultaneously is counted as the total number of separate tests or procedures of which it is comprised. Calculations such as A/G ratio, MCH, MCHC and T_3 are an exception and should not be included in the total count. Examples: A chemistry profile consisting of 18 separate procedures is counted as 18 separate procedures. In the same manner, a CBC is counted as each individual measured (not calculated) analyte and as one test for the differential. For microbiology, susceptability testing is counted as one test per group of antiobiotics used to determine sensitivity for one organism.

If applying for certificate of accreditation, indicate name of current accrediting body beside applicable specialty/subspecialty.

SPECIALTY / SUBSPECIALTY	ACCREDITED PROGRAM	ANNUAL TEST VOLUME
Histocompatibility		
Transplant		
☐ Non-transplant		
Microbiology		
Bacteriology		
Mycobacteriology		
Mycology		
Parasitology		
Virology		
Other		
Diagnostic Immunology		
Syphilis Serology		
General Immunology		
Chemistry		
Routine		
Urinalysis		
Endocrinology		
Toxicology		
☐ Other		

SPECIALTY / SUBSPECIALTY	ACCREDITED PROGRAM	ANNUAL TEST VOLUME
☐ **Hematology**		
☐ **Immunohematology**		
☐ ABO Group & Rh Group		
☐ Antibody Detection (transfusion)		
☐ Antibody Detection (nontransfusion)		
☐ Antibody Identification		
☐ Compatibility Testing		
☐ Other		
☐ **Pathology**		
☐ Histopathology		
☐ Oral Pathology		
☐ Cytology		
☐ **Radiobioassay**		
☐ **Clinical Cytogenetics**		
TOTAL ANNUAL TEST VOLUME		

IX. TYPE OF CONTROL

Enter the appropriate two digit code from the list below _____ _____ *(enter only one code)*

Voluntary Nonprofit
01 Religious Affiliation
02 Private
03 Other

For Profit
04 Proprietary

Government
05 City
06 County
07 State
08 Federal
09 Other Government

X. TYPE OF OWNERSHIP

Enter the appropriate two digit code from the list below _____ _____ *(enter only one code)*

01 Sole Proprietorship
02 Partnership
03 Corporation
04 Other *(specify)*

_____

XI. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the primary director of this laboratory serves as primary director for laboratories that are separately certified, please complete the following:

NAME OF LABORATORY	ADDRESS	CLIA IDENTIFICATION NUMBER

XII. INDIVIDUALS INVOLVED IN LABORATORY TESTING

Indicate the total number of individuals involved in laboratory testing (directing, supervising, consulting or testing). Do not include individuals who only collect specimens or perform clerical duties. For nonwaived testing, only count an individual one time, at the highest laboratory position in which they function. (Example Pathologist serves as director, technical supervisor and general supervisor. This individual would only be counted once (under director)).

A. Waived TOTAL No. of Individuals _____

B. Nonwaived TOTAL No. of Individuals _____

Director _____ Technical supervisor _____
Clinical consultant _____ General supervisor _____
Technical consultant _____ Testing personnel _____

ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION

ANY PERSON WHO INTENTIONALLY VIOLATES ANY REQUIREMENT OF SECTION 353 OF THE PUBLIC HEALTH SERVICE ACT AS AMENDED OR ANY REGULATION PROMULGATED THEREUNDER SHALL BE IMPRISONED FOR NOT MORE THAN ONE YEAR OR FINED UNDER TITLE 18, UNITED STATES CODE OR BOTH, EXCEPT THAT IF THE CONVICTION IS FOR A SECOND OR SUBSEQUENT VIOLATION OF SUCH A REQUIREMENT SUCH PERSON SHALL BE IMPRISONED FOR NOT MORE THAN 3 YEARS OR FINED IN ACCORDANCE WITH TITLE 18, UNITED STATES CODE OR BOTH.

CONSENT: THE APPLICANT HEREBY AGREES THAT SUCH LABORATORY IDENTIFIED HEREIN WILL BE OPERATED IN ACCORDANCE WITH APPLICABLE STANDARDS FOUND NECESSARY BY THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CARRY OUT THE PURPOSES OF SECTION 353 OF THE PUBLIC HEALTH SERVICE ACT AS AMENDED. THE APPLICANT FURTHER AGREES TO PERMIT THE SECRETARY, ANY FEDERAL OFFICER OR EMPLOYEE DULY DESIGNATED BY THE SECRETARY, TO INSPECT THE LABORATORY AND ITS OPERATIONS AND PERTINENT RECORDS AT ANY REASONABLE TIME.

SIGNATURE OF OWNER/AUTHORIZED REPRESENTATIVE OF LABORATORY *(sign in ink)* | DATE

last *first* *MI*

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

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IS11-39 **Health Evaluation of Offenders In Disciplinary Segregation (Essential)** **Effective Date: October 15, 1999**

Ralf J. Salke
Regional Manager

Gary H. Campbell, D.O.
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

R. Dale Riley, Director
Division of Offender
Rehabilitation Services

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I. **Purpose:** This procedure ensures offenders placed in disciplinary segregation do not have any contraindicating medical conditions and that their continuing health status does not deteriorate during confinement.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Disciplinary Segregation:** Special housing to which offenders are temporarily assigned when found guilty of rule infractions.

III. **PROCEDURES:**

A. When a disciplinary hearing is held and a sanction of disciplinary segregation assignment is issued, the disciplinary hearing officer should notify the health care unit of the names of the offenders being assigned.

B. The medical record should be reviewed for medical conditions, which would contraindicate confinement prior to placement of an offender in disciplinary segregation.

C. The offender should be examined for the presence of any acute illness or injuries, which would preclude confinement.

D. Findings should be documented on the initial assessment section of the Disciplinary Segregation Medical Documentation form (Attachment A).

E. The classification staff should be advised of any medical conditions, which contraindicate the offender's placement in disciplinary segregation.

F. Daily rounds by the nursing staff should be made in disciplinary segregation to evaluate each offender for their continuing health status.

G. The Disciplinary Segregation Medical Documentation form (Attachment A) should be used to document the initial assessment and daily rounds.

H. Daily encounters that do not lead to further evaluation do not need to be documented in MARS. Encounters requiring medical intervention should be made and documented in the offender's medical record in MARS.

IV. ATTACHMENTS:

A. 931-3762 Segregation Medical Documentation Form

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 1997. P-39

VI. HISTORY:

This policy was originally covered by IS11-43, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

DEPARTMENT OF CORRECTIONS

SEGREGATION MEDICAL DOCUMENTATION

NAME	DOC NUMBER	RACE	DATE OF BIRTH	HOUSING UNIT	CELL NUMBER

...TRATIVE SEGREGATION	DISCIPLINARY SEGREGATION	DATE CONFINED	INSTITUTION

...NITIAL ASSESSMENT	VITAL SIGNS ▶	BP	P	R	TEMPERATURE

SIGN OF TRAUMA ☐ YES ☐ NO DESCRIBE

MEDICAL/MENTAL HEALTH COMPLAINTS ☐ YES ☐ NO DESCRIBE

DATE OF LAST PHYSICAL

EXISTING MEDICAL/MENTAL HEALTH CONDITIONS ☐ YES ☐ NO DESCRIBE

Y=YES N=NO

DATE

TIME ☐ A.M. ☐ P.M.

DATE/TIME																															
CRYING	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
SIGNS OF TRAUMA	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ORIENTED X 3	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
WITHDRAWN	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
...LE/ANGRY	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
...T	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
MANIC BEHAVIOR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
DENIES COMPLAINT	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
NURSE'S SIGNATURE																															

COMMENTS (BY DATE) ANY YES RESPONSE REQUIRES FURTHER EVALUATION AND DOCUMENTATION.

MO 931-3782 (2-97)

DATE/TIME																														
CRYING	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
NS OF TRAUMA	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ORIENTED X 3	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
WITHDRAWN	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
HOSTILE/ANGRY	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
QUIET	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
MANIC BEHAVIOR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
DENIES COMPLAINT	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
NURSE'S SIGNATURE																														

COMMENTS (BY DATE) ANY YES RESPONSE REQUIRES FURTHER EVALUATION AND DOCUMENTATION.

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

****

IS11-38 **Sick Call (Essential)** **Effective Date: October 15, 1999**

Ralf J. Salke
Regional Manager

Gary H. Campbell, D.O.
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

R. Dale Riley, Director
Division of Offender
Rehabilitation Services

****

I. **Purpose:** This procedure provides offenders with an appropriate evaluation and treatment by qualified health care staff for non-emergent health requests.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Sick call**: The system by which offenders report for and receive appropriate health services for non-emergent health requests.

B. **SOAP format**: A charting/recording process which reflects subjective complaints, objective findings, an assessment and a treatment plan.

III. **PROCEDURES:**

A. Scheduling for sick call should be made according to policy and procedure IS11-37, Daily Handling Of Non-Emergency Medical Requests.

1. Non-emergency requests should be triaged within 24 hours of receipt of the request and the offender seen within the next 24 hours (72 hours on weekends or holidays).

B. Sick call should be scheduled five (5) days a week, excluding holidays.

C. Sick call should be scheduled using the Medical Accountability Records System (MARS) as the sick call log for scheduling purposes.

D. The Sick Call Log should document if the offender was seen, was a no-show, and/or was referred to the physician, mental health staff or dentist. The call-out docket generated by the Medical Accountability Records System may be utilized as the sick-call log.

E. Nursing protocols should be utilized for minor health care complaints as indicated by approved protocols.

F. As a general rule, any offender who has been seen in sick call more than twice for the same complaint, but has not yet seen a physician, should be scheduled to see the physician.

G. If an offender presents with the same complaint more than twice and is currently being followed for the complaint, an appointment may not be necessary. The physician should be notified and appropriate orders given.

H. Offenders requiring referral to the physician should be seen within seven (7) working days.

I. Offender encounters should be documented in the Medical Accountability Records System. The Medical Services Request form (Attachment A) should note that the encounter has been documented in the Medical Accountability Records System, signed by the health care provider with time, and date and placed in the offenders hard copy medical chart.

J. All offender encounters should be documented using the SOAP format. Vital signs should be included in objective information.

K. Daily sick call logs should be maintained in the medical unit by the medical staff and monthly statistics should be generated for the Health Services Report.

IV. ATTACHMENTS:

A. 931-1319 Medical Services Request Form

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 1997. P-38
B. IS11-37 Daily Handling of Non-Emergency Medical Requests

VI. HISTORY:

This policy was originally covered by IS 11-38, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

MEDICAL SERVICES REQUEST

'S NAME	NAME OF INSTITUTION	
	REGISTER NUMBER	DATE
HOUSING UNIT	WORK ASSIGNMENT	

CHIEF COMPLAINT

CURRENT MEDICATIONS

WHICH EXISTING DISEASES HAVE BEEN DIAGNOSED?

PATIENT'S SIGNATURE	DATE	TIME

NURSING ASSESSMENT (USE SOAP FORMAT)

SIGNATURE	DATE	TIME

SICIAN VISIT NOTES (USE SOAP FORMAT)

PHYSICIAN'S ORDERS

SUBSTITUTION PERMITTED			DISPENSE AS WRITTEN		
PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE	DATE	TIME

MO 931-1319 (9-92)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

MEDICAL SERVICES REQUEST

PATIENT NAME (PLEASE PRINT)		INSTITUTION	DATE RECEIVED BY MEDICAL
		DOC NUMBER	DOB / DATE
HOUSING UNIT		WORK/SCHOOL SCHEDULE	
I WISH TO BE SEEN BY (CHECK ONE) ☐ MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ OTHER		FOR	
REQUESTING OVER THE COUNTER (OTC) MEDICATION ONLY ☐ WHAT MEDICATION?		WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?	
WHAT EXISTING MEDICAL CONDITIONS HAVE BEEN DIAGNOSED?			
PATIENT SIGNATURE AND AUTHORIZATION TO TREAT		INITIAL FOR RECEIPT OF OTC INSTRUCTIONS	DATE / TIME

DO NOT WRITE BELOW THIS LINE - FOR MEDICAL USE ONLY

TRIAGE NURSE — DATE

☐ Routine ☐ Urgent ☐ Emergent
☐ Mental Health Visit Scheduled ☐ Doctor Review, No Visit/Last Seen _____
☐ To DON ☐ Medication Rm
☐ To Dental ☐ Doctor Sick Call
☐ To Optometry ☐ Nurse Sick Call
☐ To Lab/X-Ray ☐ To Administrator

SCHEDULING

☐ Appointment Scheduled _____ (Initials)
☐ Protocol Code to be Scheduled: _____
☐ Complaint Code to be Scheduled (If No Protocol Available): _____ See Current Listing (F19)

NURSING VISIT

VITALS
T _____ P _____ R _____ B/P _____ Wt. _____

ORTHOSTATIC VITALS	STANDING	SITTING	LYING
	BP _____ P _____	BP _____ P _____	BP _____ P _____

☐ Documentation in computerized medical record
☐ Protocol completed
☐ Follow up in _____ days per MSR if no improvement

NURSE SIGNATURE — DATE / TIME

PHYSICIAN VISIT

☐ Documentation in computerized medical record
☐ Medically Unnecessary or Cosmetic Procedure
☐ Follow up in _____ days per MSR if no improvement
☐ Referral or Non-Formulary Medication requested via computer

PHYSICIAN SIGNATURE — DATE / TIME

MEDICAL ACTION TAKEN	DATE/INITIALS	MEDICAL ACTION TAKEN	DATE/INITIALS
☐ Follow Up Physician Visit Scheduled		☐ Chronic Care Clinic Visit Scheduled	
☐ Follow Up Nursing Visit Scheduled		☐ Laboratory Test(s) Ordered / Scheduled	
☐ Follow Up Nurse Practitioner Visit Scheduled		☐ X-Ray(s) Ordered / Scheduled	
☐ Pending Referral or Non-Formulary		☐ Medications ordered	
☐ Follow up with Physician when above is completed.			

OFFENDER NAME	DOC NUMBER	INSTITUTION	HOUSING UNIT

MEDICAL ACTION TAKEN	DATE/INITIALS	MEDICAL ACTION TAKEN	DATE/INITIALS
☐ Follow Up Physician Visit Scheduled		☐ Chronic Care Clinic Visit Scheduled	
☐ Follow Up Nursing Visit Scheduled		☐ Laboratory Test(s) Ordered / Scheduled	
☐ Follow Up Nurse Practitioner Visit Scheduled		☐ X-Ray(s) Ordered / Scheduled	
☐ Pending Referral or Non-Formulary		☐ Medications Ordered	
☐ Other			

REVIEWED BY — DATE / TIME

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

MEDICAL SERVICES REQUEST

NAME OF INSTITUTION

.NT'S NAME

REGISTER NUMBER | DATE

HOUSING UNIT

WORK ASSIGNMENT

CHIEF COMPLAINT

CURRENT MEDICATIONS

WHICH EXISTING DISEASES HAVE BEEN DIAGNOSED?

PATIENT'S SIGNATURE | DATE | TIME

NURSING ASSESSMENT (USE SOAP FORMAT)

E'S SIGNATURE | DATE | TIME

PHYSICIAN VISIT NOTES (USE SOAP FORMAT)

PHYSICIAN'S ORDERS

SUBSTITUTION PERMITTED

PHYSICIAN SIGNATURE | DATE | TIME

DISPENSE AS WRITTEN

PHYSICIAN SIGNATURE | DATE | TIME

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-37.1	**Daily Handling of Non-Emergency Medical Requests (Essential)**	**Effective Date: October 15, 1999**

Ralf J. Salke
CMS Regional Manager

Gary H. Campbell, D.O.
CMS Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

R. Dale Riley, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure provides offenders with access to qualified health care providers for non-emergency health care needs.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **MARS:** Medical Accountability Records System

III. **PROCEDURES:**

A. Offenders should have access to non-emergency medical, dental, and optometry services by submitting a written request that is triaged by a qualified health care staff member on a daily basis. If appropriate staff are not on-site, nursing staff will determine if an emergency exists.

B. A designated health care staff member should make rounds in segregation areas daily to solicit health care requests from segregated offenders.

C. Medical Services Request Forms (Attachment A) should be provided in each housing unit.

D. Segregation rounds should be documented on the Segregation Medical Documentation Form (Attachment B).

E. The Medical Services Request form should be collected daily, by medical staff, at scheduled times in each housing unit. These forms should be stamped with the date of receipt and retained in the medical record for potential retrieval.

F. The nurse making the assessment should document the triage decision or offender assessment in MARS.

G. Any offender with a request suggesting the problem may be of an emergency nature (i.e., chest pain) should receive prompt attention.

H. Non-emergency requests should be scheduled for the appropriate level of sick call by the nursing staff.

I. A MARS generated sick call log of all offenders who have requested and been scheduled for health care should be prepared by the nursing staff.

J. The MARS generated sick call log should be placed in a designated area for medical record retrieval in preparation for sick call.

K. Arrangements for offender movement should be made in accordance with institutional procedures

IV. ATTACHMENTS

A. 931-1319 Medical Services Request Forms
B. 931-3762 Segregation Medical Documentation

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 1997. P-37.
B. IS11-39 Health Evaluation of Offenders in Disciplinary Segregation
C. IS11-45 Health Evaluation of Offenders in Administrative Segregation and Protective Custody

VI. HISTORY:

This policy was originally covered by IS11-37, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

SEGREGATION MEDICAL DOCUMENTATION

NAME	DOC NUMBER	RACE	DATE OF BIRTH	HOUSING UNIT	CELL NUMBER

STRATIVE SEGREGATION	DISCIPLINARY SEGREGATION	DATE CONFINED	INSTITUTION

INITIAL ASSESSMENT	VITAL SIGNS ▶	BP	P	R	TEMPERATURE

SIGN OF TRAUMA ☐ YES ☐ NO DESCRIBE

MEDICAL/MENTAL HEALTH COMPLAINTS ☐ YES ☐ NO DESCRIBE

DATE OF LAST PHYSICAL

EXISTING MEDICAL/MENTAL HEALTH CONDITIONS ☐ YES ☐ NO DESCRIBE

Y=YES N=NO

DATE

TIME ☐ A.M. ☐ P.M.

DATE/TIME																														
CRYING	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
SIGNS OF TRAUMA	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ORIENTED X 3	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
WITHDRAWN	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
HOSTILE/ANGRY	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
T	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
MANIC BEHAVIOR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
DENIES COMPLAINT	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
NURSE'S SIGNATURE																														

COMMENTS (BY DATE) ANY YES RESPONSE REQUIRES FURTHER EVALUATION AND DOCUMENTATION.

DATE/TIME																														
CRYING	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
SIGNS OF TRAUMA	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ORIENTED X 3	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
WITHDRAWN	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
HOSTILE/ANGRY	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
QUIET	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
MANIC BEHAVIOR	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
DENIES COMPLAINT	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
NURSE'S SIGNATURE																														

COMMENTS (BY DATE) ANY YES RESPONSE REQUIRES FURTHER EVALUATION AND DOCUMENTATION.

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-36.1 **Dental / Oral Care** **Effective Date: August 27, 2003**

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** To ensure dental/oral care is provided to each offender in a timely manner and is under the direction and supervision of a licensed dentist.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Oral Care:** Includes instruction in oral hygiene, examination, and treatment of dental problems. Instruction in oral hygiene minimally includes information on plaque control and the proper brushing of teeth.

B. **Oral Screening:** Includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

C. **Oral Examination:** By a dentist includes taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination.

D. **Oral Treatment:** Includes the full range of services that in the supervising dentist's judgment are necessary for proper mastication and maintaining the offender's health status.

E. **Infection Control:** Practices defined by the American Dental Association and Centers for Disease Control and Prevention to include sterilizing instruments, disinfecting equipment, and properly disposing of hazardous waste.

III. **PROCEDURES:**

A. During the health assessment, health care staff should observe the offender's teeth and gums to identify any gross abnormalities requiring immediate referral to the dentist. The offender should be provided information on oral hygiene verbally and in writing (Tooth Decay and Gum Disease-What You and Your Dentist Can Do About Them) (Attachment A). This should be documented in the medical file on the Dental Treatment Record (Attachment B) and done within 7 days of admission.

B. Oral screening by the dentist or qualified health care professional trained by the dentist should be performed within 7 days of initial intake incarceration.

C. An oral examination should be performed by the dentist within 30 days of initial intake incarceration.

D. Offenders submitting a request for dental treatment should be triaged by health care staff and referred to the dental department for scheduling and treatment.

1. Routine care include:
   a. lost filling (s)
   b. sensitivity to hot or cold
   c. teeth need to be cleaned
   d. broken clasp of partial plate
   e. partial adjustment

2. The following problems should be seen by or discussed with the dentist or physician as soon as possible:
   a. post-extraction bleeding 2nd day after extraction
   b. severe redness associated with pain
   c. swollen gums and jaws
   d. severe pain in extraction site two or more days after extraction
   e. injuries with very painful or fractured teeth or if the offender cannot close her/his mouth after being hit in the jaw.

D. Treatment should be provided in accordance with a treatment plan determined by the treating dentist. In general, treatment should be prioritized using the following guidelines:

Dental Treatment Priorities

Priority	Category of Treatment	Description of Need	Eligibility by Length of Incarceration
1.	Emergency/Urgent	Individuals requiring emergency/ urgent dental treatment for relief of acute oral and maxillofiacial conditions characterized by trauma, infection, pain, swelling or bleeding which are likely to remain acute or worsen without intervention; unusual hard or soft tissue pathology.	All

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Dental Treatment Priorities Cont'd

Priority	Category of Treatment	Description of Need	Eligibility by Length of Incarceration
2a.	Patient Education/ Prevention	Individuals requiring basic education in the understanding and recognition of oral disease processes and basic skills development in oral self-care and plaque control procedures through the use of visual aids, demonstration and Oral Hygiene Indexes (documented) and provided on an individual or small group basis.	All
b.	Prosthodontic, Full Denture	Edentulous	All
3.	Corrective	Individuals requiring treatment for chronic oral pathosis and for the restoration of essential function.	
a.	Clinical Hygiene/ Periodontic	Periodontitis: Type I: Gingivitis-shallow pockets, no bone loss. Type II: Early Periodontitis-moderate pockets, minor to moderate bone loss, satisfactory topography. Type III: Moderate Periodontitis-moderate to deep pockets, moderate to severe bone loss, unsatisfactory topography. Type IV: Advanced Periodontitis-deep pockets, severe bone loss, advanced mobility patterns.	All
b.	Restorative	Caries advanced into dentin and patients has demonstrated (documented) an acceptable level of plaque control.	Over 6 Months*
c.	Endodonic	Anterior, restorable non-vital teeth in an otherwise healthy mouth and which, if retained, would preclude the need for a prosthetic replacement and patient has demonstrated (documented) an acceptable level of plaque control.	Over 6 Months*

Dental Treatment Priorities – Cont'd

Priority	Category of Treatment	Description of Need	Eligibility by Length of Incarceration
d.	Oral Surgery	Asymptomatic non-restorable erupted teeth.	Over 6 Months*
		Chronically symptomatic impacted teeth.	Over 6 Months*
		Surgical procedures for the elimination of pathosis or restoration of essential physiologic relationships.	
e.	Prosthodontic (Removable 1) Partial Dentureteeth	Insufficient number of teeth to masticate a normal diet (7 or fewer occluding posterior may be considered to be an insufficient number) and patient has demonstrated for two consecutive clinic visits an acceptable level of plaque control (documented by disclosing plaque) and patient has no other unmet Priority 3 needs (excepting definitive treatment Types III and IV Periodontitis).	All
	2) Reline/Repair	As needed.	All
	3) Esthetic Anterior	Although not needed to restore essential function one or more missing anterior teeth may be replaced after patient has demonstrated for two consecutive clinic visits an acceptable level of plaque control (documented by disclosing plaque) and there is not a scheduling backlog of over five weeks for other prosthetics needed to restore essential function.	
4.	Elective	Individuals apparently requiring no Priority 1, 2 or 3 dental treatment. (Elective treatment will not be provided).	N/A

*Excepting patients requiring Priority 3 prosthetics for the restoration of essential function.

E. A designated health care staff member should maintain a system to schedule dental examination for all offenders within (7) days after admission to a diagnostic center.

F. Dental examinations and plans should be documented on the Dental Treatment/Services Rendered Record (Attachment B).

G. Arrangements should be made for consultation with referral to specialists in dentistry for oral surgery as needed. See IS11-30 Hospital and Specialized Ambulatory Care.

H. Dental emergencies should be responded to immediately.

I. Dental prophylaxis should be performed when prescribed by the dentist. Flouride toothpaste or fluoride oral rinses should be available to all offenders.

J. A daily appointment log with procedures performed will be kept and used for generating monthly statistics of dental services for the health services report.

IV. ATTACHMENTS

A.		Tooth Decay and Gum Disease Literature.
B.	931-3745	Dental Treatment Record

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-E-06 Oral Care – *essential.*
B. IS11-30 Hospital and Specialized Ambulatory Care
C. IS11-14.1 Infection Control Program
D. IS11-14.5 Personal Protective Equipment
E. IS11-15 Environmental Health and Safety
F. IS11-15.1 Disposal of Regulated Waste

VI. HISTORY: This policy was originally covered by IS11-36.1, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date:	

How to get the most from your home care routin

You can help improve your oral hygiene by making plaque and calculus (tartar) control part of your daily routine.

Proper brushing helps remove plaque from the outer, inner, and chewing surfaces of your teeth. This is an accepted method for proper brushing. Your dentist or hygienist may suggest another.

Flossing thoroughly helps remove plaque and debris from between the teeth, especially in hard-to-reach areas at and slightly under the gumline. Here is a suggested flossing technique.

Between office visits, use a fluoride toothpaste that reduces tartar formation and protects against cavities. Now there's help for you . . . Tartar Cor Crest.® Tartar Control Crest helps prevent the fc mation of calculus (tartar) above the gumline between professional cleanings. **It is essential to b a routine prophylaxis for the removal of calculus (tartar) forming below the gumline.** Tartar Contr Crest is clinically proven safe for dental enamel a gums. It provides the same cavity-fighting benefi the other members of the Crest family, and is accepted by the American Dental Association as effective decay-preventive dentifrice.

Brush after every meal and especially thoroug once a day.

How to brush

1. Outside of front teeth.
Hold your toothbrush at a 45° angle and place it where your teeth and gums meet. Move the brush back and forth in a gentle scrubbing motion to remove plaque from the outer surfaces of the front teeth, upper and lower.

2. Outside of back teeth.
Continue brushing with short, angled strokes to remove plaque from the outer surfaces of the back teeth, upper and lower.

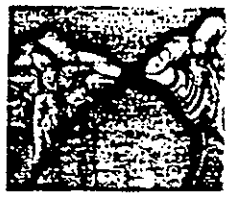
3. Inside of back teeth.
Keep brushing with short, angled strokes to remove plaque from the inner surfaces of the back teeth, upper and lower.

4. Inside of front teeth.
Tilt the brush vertically and make up-and-down strokes to remove plaque from the inner surfaces of the front teeth, upper and lower.

5. Chewing surfaces.
Hold the brush flat and use a scrubbing motion to remove plaque from the chewing surfaces of all teeth, upper and lower.

How to floss

1. Setting up.
Pull about 18 inches of floss from the dispenser and wrap the ends around your middle fingers.



2. Inserting floss.
Hold floss tightly, using your fingers to gently guide the floss between the teeth. Work floss through the contact point, moving it gently under the gumline. Be careful not to snap the floss between teeth and under gums, as this can harm delicate tissue.

3. Removing plaque.
Holding the floss tightly against the tooth, move the floss away from the gum, scraping the floss up and down against the side of the tooth.

4. Cleaning the whole mouth.
Repeat flossing procedure on each tooth, upper and lower, using a clean segment of floss.

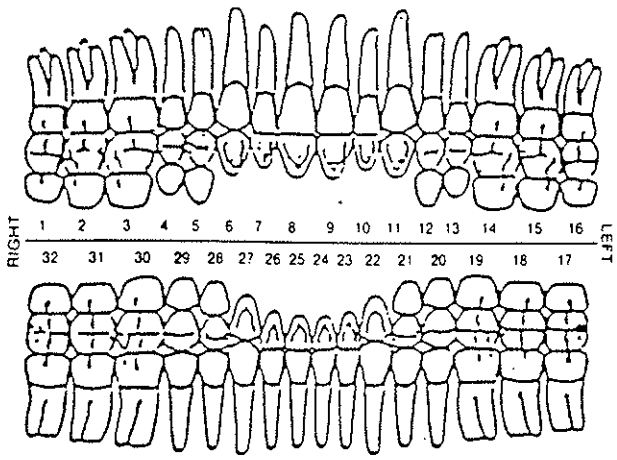
5. Flossing back teeth.
Don't forget to floss behind back teeth or where there is no adjacent tooth.

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

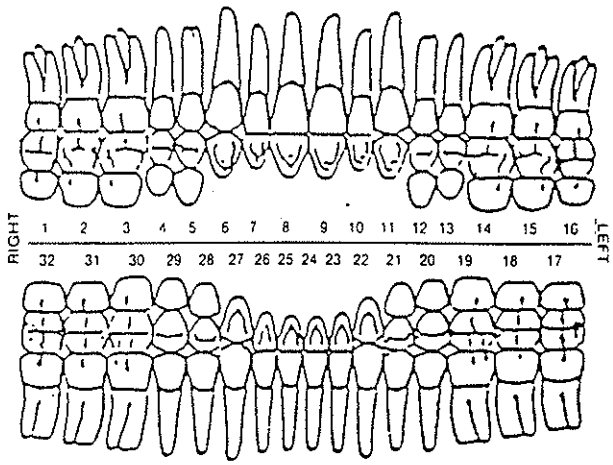
DENTAL TREATMENT RECORD

	DOC NUMBER	RACE	DOB

DENTAL EXAMINATION



RESTORATION AND TREATMENTS



Date of Initial Examination:	TOOTH	PRIORITY LIST
Initial Classification:		
Oral Pathology:		
jivitis		
cent's Infection		
ıatis		
Other Findings		
Occlusion		
Roentgenograms:		
Periapical		
Bitewine		
Panarex		

HEALTH QUESTIONNAIRE	YES	NO		YES	NO
Are you in good health?			Acquired Immune Deficiency (AIDS/HIV)?		
Allergies			Gastrointestinal disorders		
Anemia			Glaucoma		
Asthma or other respiratory problems			Heart disease or murmer		
Blood pressure conditions			Hepatitis		
Diabetes			Kidney problems		
Epilepsy			Reactions to anesthetics or medications		
ɔsive bleeding after surgery			Rheumatic fever		
ing			Taking any medication		
Pregnant?			Thyroid conditions		
uberculosis			Other conditions		

1745 (7-94)

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-35 **Intake Mental Health Assessment** **Effective Date: October 6, 2003**

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure is to ensure the serious mental health needs, including developmental disability and or addictions are identified during intake process and prevent deterioration of level of functioning and to ensure necessary treatment is provided in a timely process.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Mental Health Staff:** Include qualified health care professional who have received instruction and supervision in identifying and interacting with individuals in need of mental health services.

B. **Qualified Mental Health Professional:** Include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

III. **PROCEDURES:**

A. A mental health assessment should be completed on all offenders within fourteen (14) days of initial intake incarceration/reception by qualified mental health personnel.

B. The initial mental health evaluation should include:

1. History of;

1. psychiatric hospitalization and outpatient treatment,
2. suicidal attempts,
3. violent or assaultive behavior,
4. sexual victimization or abuse,
5. special education placement,
6. cerebral trauma or seizures,
7. sex offenses,
8. physical or psychological abuse, and/or
9. drug or alcohol use.

2. Current status of:

1. psychotropic medications,
2. suicidal ideation,
3. drug or alcohol use, and
4. orientation to person, place, and time;

3. Emotional response to incarceration.

4. Screening for intellectual functioning (i.e., mental retardation, developmental disability, and learning disability).

5. Offenders with positive screening for mental health problems are referred to qualified mental health professionals for further evaluation. (IS12-1 Initial Evaluation and Referral Services, IS12-03 Mental Health Programs/Facilities, IS 12-03.3 Social Rehabilitation Units, IS12-03.4 Special Needs Unit).

6. The health record should contain results of the evaluation with documentation of referral or initiation of treatment when indicated.

C. The mental health evaluation should be performed by:

1. completing the Intake Mental Health Screening form (Attachment A) by a mental health staff member.

2. interview of the offender by classification caseworkers and documented on the Mental Health Initial Classification Analysis form (Attachment B).

3. psychological testing, if indicated, conducted by the psychologist and documented on the Psychological Evaluation Referral (Confidential) form (Attachment C).

D. Offenders requiring specialized placement or treatment related to mental disorders or limited cognitive function should be scheduled for follow-up by the mental health staff.

E. Any mental health evaluation forms should be filed in the medical record. Documentation of on-going monitoring should be scheduled by the mental health staff.

IV. ATTACHMENTS

A. 931-3757 Intake Mental Health Screening Form

B.	931-0354	Initial Classification Analysis (ICA) Mental Health Care
C.	931-1572	Psychological Evaluation Referral (Confidential) Form

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-E-05 Mental Health Screening and Evaluation – *essential.*
B. IS11-34.1 Health Assessment at Reception
C. IS12-01 Initial Evaluation and Referral Services
D. IS12-02 Referral Procedures to Mental Health Section
E. IS12-03 Mental Health Programs/Facilities
F. IS12-03.3 Social Rehabilitation Units
G. IS13-03.4 Special Needs Unit
H. IS12-04 Crisis Intervention
I. IS12-05 Services to Special Management Units

VI. HISTORY:

This policy was originally covered by IS11-35.1, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date:	

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INTAKE MENTAL HEALTH SCREENING

ENDER NAME	DOC NUMBER	RACE	DATE OF BIRTH

SUICIDE POTENTIAL SCREENING	(CIRCLE)	
1. ARRESTING OR TRANSPORTING OFFICER BELIEVES SUBJECT MAY BE SUICIDE RISK	YES	NO
2. LACKS CLOSE FAMILY/FRIENDS IN COMMUNITY	YES	NO
3. EXPERIENCED A SIGNIFICANT LOSS WITHIN LAST 6 MONTHS (LOSS OF JOB, RELATIONSHIP, DEATH OF CLOSE FAMILY MEMBER).	YES	NO
4. WORRIED ABOUT MAJOR PROBLEMS OTHER THAN LEGAL SITUATION (TERMINAL ILLNESS).	YES	NO
5. EXPRESSES THOUGHTS ABOUT KILLING SELF.	YES	NO
6. HAD A SUICIDE PLAN AND/OR SUICIDE INSTRUMENT IN POSSESSION.	YES	NO
7. HAD PREVIOUS SUICIDE ATTEMPT. (CHECK WRISTS & NOTE METHOD).	YES	NO
8. EXPRESSES FEELINGS THAT THERE IS NOTHING TO LOOK FORWARD TO IN THE FUTURE (FEELINGS OF HELPLESSNESS AND HOPELESSNESS).	YES	NO
9. SHOWS SIGNS OF DEPRESSION (CRYING, EMOTIONAL FLATNESS).	YES	NO
10. APPEARS OVERLY ANXIOUS, AFRAID OR ANGRY.	YES	NO
11. APPEARS TO FEEL UNUSUALLY EMBARRASSED OR ASHAMED.	YES	NO
IS ACTING AND/OR TALKING IN A STRANGE MANNER. (CANNOT FOCUS ATTENTION; HEARING OR SEEING THINGS NOT THERE).	YES	NO
S APPARENTLY UNDER THE INFLUENCE OF ALCOHOL OR DRUGS.	YES	NO
IF YES TO #13, IS INDIVIDUAL INCOHERENT OR SHOWING SIGNS OF WITHDRAWAL OR MENTAL ILLNESS.	YES	NO
TOTAL YES'S = IF THERE ARE ANY CIRCLES IN SHADED AREAS, OR TOTAL OF YES'S IS 6 OR MORE, ALERT SHIFT SUPERVISOR AND REFER FOR MENTAL HEALTH EVALUATION.		

MENTAL HEALTH HISTORY	(CIRCLE)	
1. NOW TAKING PSYCHOTROPIC MEDICATION? TYPE: CURRENT DOSAGE: SOURCE:	YES	NO
2. HISTORY OF PSYCHIATRIC HOSPITALIZATION? WHEN: WHERE:	YES	NO
3. HISTORY OF OUTPATIENT MENTAL HEALTH TREATMENT? WHEN: WHERE:	YES	NO

MENTAL HEALTH HISTORY (CON'T)	(CIRCLE)	
4. HISTORY OF VIOLENCE OR ASSAULT TO CAUSE INJURY ONLY? WHEN:	YES	NO
5. HISTORY OF SEX OFFENDING? WHEN:	YES	NO
6. HISTORY OF BEING SEXUALLY VICTIMIZED? WHEN: WHERE:	YES	NO
7. HISTORY OF SERIOUS HEAD TRAUMA WITH LOC AND/OR SEIZURES? WHEN:	YES	NO

BEHAVIORAL OBSERVATIONS
CIRCLE AND COMMENT ON ANY PROBLEMS IN THE FOLLOWING AREAS:

- GROOMING & HYGIENE:
- MOTOR ACTIVITY:
- ATTENTION & CON:
- ORIENTATION (PERSON/PLACE/TIME/SITUATION):
- SPEECH RATE:
- UNUSUAL SPEECH CONTENT (HALLUCINATIONS, DELUSIONAL IDEAS):
- MOOD & EMOTIONALITY:
- PROBLEMS WITH EXPRESSING SELF OR UNDERSTANDING INSTRUCTIONS (IQ CONCERN):

MENTAL HEALTH NEEDS AND TREATMENT DISPOSITION

☐ No current mental health problems / No mental health history / Approved for general population housing.

☐ No current mental health problems / Reports mental health history / Approved for general population housing.

ive mental disorder symptoms / Refer to qualified mental health staff, **ASAP.**

Acutely suicidal, homicidal or psychotic / **Emergency** referral to qualified mental health staff.

SCREENED BY	DATE	TIME	☐ A.M. ☐ P.M.
REVIEWED BY QUALIFIED MENTAL HEALTH PROFESSIONAL	DATE	TIME	☐ A.M. ☐ P.M.

DISTRIBUTION: WHITE - MEDICAL FILE CANARY - MENTAL HEALTH UNIT

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INITIAL CLASSIFICATION ANALYSIS (ICA) MENTAL HEALTH CARE

INMATE NAME	REGISTER NUMBER	DATE

Instructions: Circle appropriate level, as indicated, and enter MH score.

MH-5 **SEVERE IMPAIRMENT** - Intensive clinical care in a psychiatric hospital setting (Biggs, CTC) required

— Activity psychotic
— Major affective/anxiety disorder
— Severe personality disorder
— Organic disorders/mental retardation resulting in severe impairment

MH-4 **SIGNIFICANT IMPAIRMENT** - Highly structured clinical care in an intermediate to long-term psychiatric unit (SRU, CTC) required

— Previous MH-5 conditions stabilized with medication
— Psychotic/paranoid symptoms
— Affective/anxiety disorder
— Significant personality disorder
— Organic disorder/mental retardation resulting in significant impairment

SIGNATURE OF AUTHORIZING PSYCHIATRIST/PSYCHOLOGIST I OR ABOVE	TITLE	MH SCORE

MH-3 **MODERATE IMPAIRMENT** - Regular clinical services indicated but capable of being maintained in open population

— Recent history of more serious disturbance, including psychosis, but stabilization for over two months
— Moderate levels of affective/anxiety disorder (including dysthymic/cyclothymic)
— Personality disorder
— Adjustment disorder
— Symptoms of organic disorder/mental retardation requiring regular clinical attention

SIGNATURE OF AUTHORIZING ASSOCIATE PSYCHOLOGIST I OR ABOVE	TITLE

MH-2 **MILD IMPAIRMENT** - Minor symptoms that may indicate periodic or maintenance clinical services (including low-dosage psychotropic medication)

— Mild personality disorder or serious history of substance abuse
— Mild symptoms which do not interfere with institutional functioning

MH-1 **MINIMAL/NO APPARENT DISTURBANCE** - No clinical services required, although there may be a history of behavioral or substance abuse problems

SCORED BY (SIGNATURE)	DATE	MH SCORE

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

PSYCHOLOGICAL EVALUATION REFERRAL (CONFIDENTIAL)

NAME	NAME OF INSTITUTION	HOUSING UNIT
	REGISTER NUMBER	DATE

REASON FOR REFERRAL: DESCRIBE BRIEFLY YOUR REASON FOR MAKING THIS REFERRAL (INCLUDE A DESCRIPTION OF OBSERVABLE BEHAVIORS ETC ATTACH I.O.C. IF NECESSARY).

REFERRING STAFF SIGNATURE	SUBMIT THIS FORM TO PSYCHOLOGIST

BELOW TO BE FILLED OUT BY PSYCHOLOGIST

ASSESSMENT/SESSION INFORMATION

RECOMMENDATIONS & SUMMARY

PSYCHOLOGIST SIGNATURE	DATE

CD 931 1572 (5-89)

DISTRIBUTION: WHITE-MEDICAL CHART CANARY-PSYCHOLOGIST PINK-CLASSIFICATION FILE

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-34.2 **Periodic Health Assessment (Essential)** **Effective Date: October 15, 1999**

Ralf J. Salke
CMS Regional Manager

Gary H. Campbell, D.O.
CMS Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

R. Dale Riley, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure ensures the health statuses of offenders are reviewed at the established frequency.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

None

III. **PROCEDURES:**

A. Health assessments should be completed on offenders whenever medically indicated, based on age, sex, and health needs.

1. A comprehensive health evaluation should be performed within seven (7) working days of arrival unless there are extenuating circumstances.

2. Offenders over the age of 49 years and those with chronic medical conditions in a chronic care clinic should receive a physical examination annually.

3. All other offenders should receive a physical examination every three (3) years and review of health status annually.

4. The following tests should be performed on intake and annually:

   a. mantoux ppd skin test (according to is11-14.2 tuberculosis control)
   b. multi-stick urine test
   c. pap smear-all females
   d. electrocardiograms on individuals 50 years and older or with a history of heart disease or hypertension.

5. The following tests will be performed during intake:

   a. HIV test (mandated by Missouri Statute)
   b. sickle cell- all black and hispanic males and females
   c. chlamydia – all females
   d. RPR
   e. gonorrhea – all females, symptomatic males
   f. pregnancy test – all females of childbearing age (on intake and within 30 days of return from furlough)
   g. dental exam and panelipse x-ray – parole violators will not have a repeat panelipse unless there has been a significant change in dental history (on intake and as ordered only).
   h. hearing test (on intake and as ordered only)
   i. vision screen (on intake and as ordered only)
   j. hepatitis screening – offenders with history of hepatitis, pregnant offenders, and at the discretion of the physician.
   k. baseline mammogram, (within 90 days), for females over 45.

B. HIV testing should also be performed at request of the offender.

C. If no documented tetanus immunization in the last 10 years, a tetanus/diphtheria immunization should be indicated at the time of the health evaluation.

D. A licensed physician or registered nurse may complete the periodic physical assessment. If done by a registered nurse, it must be reviewed and signed by a licensed physician. The assessment will be documented in MARS on the physical screen.

E. A licensed physician should determine m-score and duty status.

F. Offenders with chronic health care needs should have health assessments based on established protocols and enrolled in the appropriate chronic care clinic.

G. Offenders without medication and/or chronic conditions should receive health assessments at the frequency established by the correctional system (i.e., Under 50 years of age every three (3) years; over 49 years of age, annually).

H. All offenders should receive annual tuberculosis screening during their birth month in accordance with IS11-14.2 Tuberculosis Control.

I. The health services administrator/designee should establish a system to identify offenders requiring health assessment. Month of birth may be used to develop a yearly schedule.

J. All documentation regarding the assessments should be placed in the offender's medical record on the MARS system.

K. All defined medical conditions are to be entered in the problem list on the MARS.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 1997. P-34.

B. IS11-14.2 Tuberculosis Control

VI. HISTORY:

This policy was originally covered by IS11-31.2, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-34.1 **Health Assessment at Reception (Essential)**

Effective Date: October 15, 1999

Ralf J. Salke
CMS Regional Manager

Gary H. Campbell, D.O.
CMS Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

R. Dale Riley, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure ensures the health status of each offender has been assessed within (7) days of reception into the prison system.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

None

III. **PROCEDURES:**

A. A health assessment of each offender should be completed within seven (7) days after reception at a diagnostic center.

B. If an offender has documented evidence of a health assessment within the previous ninety (90) days, (e.g., parole violators), the medical director should determine the need for, and the extent of a new health assessment.

C. Health assessments should be conducted at the receiving facility if an offender is transferred from the reception center prior to the completion of the health assessment.

D. The health assessment should be reviewed and approved by the medical director.

E. Qualified and trained health care staff members should complete the health history and vital signs. An appropriately trained registered nurse, physician assistant, nurse practitioner, or physician should perform the physical examination.

F. The health assessment should include:

1. review or completion of information on Medical History and Screening Form (including significant family medical history) (Attachment A).

2. completion of the Intake Mental Health Screening form (Attachment B).

3. collection of additional data to complete the medical, dental, mental health, and immunization histories.

4. laboratory and/or diagnostic test results to detect communicable diseases, including sexually transmitted diseases and tuberculosis (See IS11-14 Sections-Infection Control and Communicable Diseases).

5. recording of height, weight, pulse, blood pressure, and temperature.

6. physical Examination.

7. observation of offender's teeth and gums to identify any gross abnormalities requiring immediate referral to the dentist.

8. pap smears and pelvic exams for female patients.

9. other tests and examinations as indicated.

10. offender instruction on oral hygiene.

11. review of the results of the medical examination, tests, and identification of problems by a physician.

12. initiation of therapy and immunizations when appropriate.

13. development and implementation of any indicated treatment plans including recommendations concerning housing, job assignment, and program participation.

14. if a female is over 45 years of age, upon reception, a baseline mammogram shall be requested within 90 days of arrival.

G. When indicated, additional investigation should be carried out regarding:

1. the use of alcohol and/or drugs.

2. current or previous treatment for alcohol or drug abuse and if so, when and where.

3. whether the offender is taking medication for an alcohol or drug abuse problem.

4. whether the offender is taking medication for a psychiatric disorder, and if so, what drugs, and for what disorder.

5. current or past illness and health problems related to substance abuse such as hepatitis, seizure, traumatic injuries, infections, liver disease.

H. The health care staff should evaluate offenders on prescription medications arriving at the reception center within 12 hours or less after arrival. The health care staff shall notify the site medical director or physician on-call to receive orders for the medications. The offender should be seen within seven (7) days for continuation of the prescription.

I. When an offender is re-admitted to the prison system, his/her health status should be updated. In the absence of changes or of a serious chronic illness, the full assessment does not need to be repeated if the health assessment has been completed within the past year.

IV. ATTACHMENTS

A. 931-2682 History Screening, History and Physical Assessment
B. 931-3757 Intake Mental Health Screening

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 1997. P-34.
B. IS11-14.1 Infection Control Program
C. IS11-14.2 Tuberculosis Control
D. IS11-14.3 Communicable Disease Isolation
E. IS11-14.4 HIV Infected Offenders
F. IS11-14.5 Personal Protective Equipment
G. IS11-14.6 HIV Testing for Offenders
H. IS11-14.7 Exposure Control Plan Bloodborne Pathogens

VI. HISTORY: This policy was originally covered by IS11-34, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

HEALTH SCREENING, HISTORY AND PHYSICAL ASSESSMENT

INSTITUTION	DATE

...TE NAME	DOC NUMBER	ALIAS, AKA

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP CODE)

NEXT OF KIN	RELATIONSHIP

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP CODE)

DATE OF BIRTH	SEX	RACE			MARITAL STATUS		
	☐ MALE ☐ FEMALE	☐ BLACK	☐ WHITE ☐ HISP.	☐ ORIEN. ☐ INDIAN	☐ SINGLE	☐ MARRIED ☐ SEPARATED	☐ DIVORCED ☐ WIDOWED

1. HAVE YOU EVER ATTEMPTED SUICIDE?	☐ YES	☐ NO
2. HEART TROUBLE?	☐ YES	☐ NO
3. SKIN RASH/ULCERATIONS	☐ YES	☐ NO
4. DO YOU HAVE ANY INJURIES?	☐ YES	☐ NO
5. ANY ALLERGIES?	☐ YES	☐ NO

IF YES, PLEASE COMPLETE: MEDICATION .....
FOODS .....
OTHER .....

6. ARE YOU ON ANY MEDICATION AT PRESENT?	☐ YES	☐ NO	IF YES, LIST .....
7. DID THE INMATE BRING MEDICATIONS WITH HIM/HER?	☐ YES	☐ NO	.....

MEDICAL HISTORY AND REVIEW OF SYSTEMS

1. HEAD, EAR, NOSE, THROAT PROBLEM	☐ YES	☐ NO	LMP _____
2. EYE PROBLEM	☐ YES	☐ NO	
MENTAL PROBLEMS	☐ YES	☐ NO	GRAVIDA ____ PARA ____ AB ____
HAVE YOU EVER ATTEMPTED SUICIDE?	☐ YES	☐ NO	
ASTHMA	☐ YES	☐ NO	LAST TETANUS SHOT _____
5. TUBERCULOSIS	☐ YES	☐ NO	
7. HEART TROUBLE	☐ YES	☐ NO	
8. HEPATITIS	☐ YES	☐ NO	
9. DIABETES	☐ YES	☐ NO	
10. VENEREAL DISEASE	☐ YES	☐ NO	
11. SEIZURE DISORDER	☐ YES	☐ NO	
12. BROKEN BONES	☐ YES	☐ NO	
13. AIDS (HIV+)	☐ YES	☐ NO	
14. CANCER	☐ YES	☐ NO	
15. SKIN RASH/ULCERATIONS	☐ YES	☐ NO	
16. DENTAL PROBLEMS	☐ YES	☐ NO	
17. ARE YOU PREGNANT?	☐ YES	☐ NO	
18. DO YOU WEAR GLASSES, BRACES OR ARTIFICIAL ARMS/LEGS?	☐ YES	☐ NO	
DO YOU HAVE THEM IN THE PRISON?	☐ YES	☐ NO	
19. SUBSTANCE ABUSE?	☐ YES	☐ NO	IF YES, WHAT? _____
20. HAVE YOU BEEN IN THIS FACILITY PREVIOUSLY?	☐ YES	☐ NO	
21. ARE YOU ON A SPECIAL DIET?	☐ YES	☐ NO	

MEDICATIONS

I hereby authorize the Missouri Department of Corrections, it's employees, agents, physicians and dentists selected to treat any medical/dental conditions I may have. Should surgical or diagnostic procedures become necessary, I will be informed of them with regard to alternate modes of treatment, risks, and nature of procedure to be done. This in no way constitutes a ...arranty or guarantee that my present condition will be cured. The Department and it's employees will provide me with the ...est care available, but no assurance of cure is to be assumed. I sign this willingly and voluntarily in full understanding of the above, and in so doing, I release the Department, it's directors, officers, employees, and physicians from any and all liability which may arise from this action, whether or not foreseen at present.

SIGNATURE OF INMATE	DATE	SIGNATURE OF ADMITTING SCREENER	DATE

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INTAKE MENTAL HEALTH SCREENING

DER NAME	DOC NUMBER	RACE	DATE OF BIRTH

SUICIDE POTENTIAL SCREENING	(CIRCLE)	
1. ARRESTING OR TRANSPORTING OFFICER BELIEVES SUBJECT MAY BE SUICIDE RISK	YES	NO
2. LACKS CLOSE FAMILY/FRIENDS IN COMMUNITY	YES	NO
3. EXPERIENCED A SIGNIFICANT LOSS WITHIN LAST 6 MONTHS (LOSS OF JOB, RELATIONSHIP, DEATH OF CLOSE FAMILY MEMBER).	YES	NO
4. WORRIED ABOUT MAJOR PROBLEMS OTHER THAN LEGAL SITUATION (TERMINAL ILLNESS).	YES	NO
5. EXPRESSES THOUGHTS ABOUT KILLING SELF.	YES	NO
6. HAD A SUICIDE PLAN AND/OR SUICIDE INSTRUMENT IN POSSESSION.	YES	NO
7. HAD PREVIOUS SUICIDE ATTEMPT. (CHECK WRISTS & NOTE METHOD).	YES	NO
8. EXPRESSES FEELINGS THAT THERE IS NOTHING TO LOOK FORWARD TO IN THE FUTURE (FEELINGS OF HELPLESSNESS AND HOPELESSNESS).	YES	NO
9. SHOWS SIGNS OF DEPRESSION (CRYING, EMOTIONAL FLATNESS).	YES	NO
10. APPEARS OVERLY ANXIOUS, AFRAID OR ANGRY.	YES	NO
11. APPEARS TO FEEL UNUSUALLY EMBARRASSED OR ASHAMED.	YES	NO
12. IS ACTING AND/OR TALKING IN A STRANGE MANNER. (CANNOT FOCUS ATTENTION; HEARING OR SEEING THINGS NOT THERE).	YES	NO
APPARENTLY UNDER THE INFLUENCE OF ALCOHOL OR DRUGS.	YES	NO
14. IF YES TO #13, IS INDIVIDUAL INCOHERENT OR SHOWING SIGNS OF WITHDRAWAL OR MENTAL ILLNESS.	YES	NO
TOTAL YES'S = IF THERE ARE ANY CIRCLES IN SHADED AREAS, OR TOTAL OF YES'S IS 6 OR MORE, ALERT SHIFT SUPERVISOR AND REFER FOR MENTAL HEALTH EVALUATION.		

MENTAL HEALTH HISTORY	(CIRCLE)	
1. NOW TAKING PSYCHOTROPIC MEDICATION? TYPE: CURRENT DOSAGE: SOURCE:	YES	NO
2. HISTORY OF PSYCHIATRIC HOSPITALIZATION? WHEN: WHERE:	YES	NO
3. HISTORY OF OUTPATIENT MENTAL HEALTH TREATMENT? WHEN: WHERE:	YES	NO

MENTAL HEALTH HISTORY (CON'T)	(CIRCLE)	
4. HISTORY OF VIOLENCE OR ASSAULT TO CAUSE INJURY ONLY? WHEN:	YES	NO
5. HISTORY OF SEX OFFENDING? WHEN:	YES	NO
6. HISTORY OF BEING SEXUALLY VICTIMIZED? WHEN: WHERE:	YES	NO
7. HISTORY OF SERIOUS HEAD TRAUMA WITH LOC AND/OR SEIZURES? WHEN:	YES	NO

BEHAVIORAL OBSERVATIONS
CIRCLE AND COMMENT ON ANY PROBLEMS IN THE FOLLOWING AREAS:

- GROOMING & HYGIENE:
- MOTOR ACTIVITY:
- ATTENTION & CON:
- ORIENTATION (PERSON/PLACE/TIME/SITUATION):
- SPEECH RATE:
- UNUSUAL SPEECH CONTENT (HALLUCINATIONS, DELUSIONAL IDEAS):
- MOOD & EMOTIONALITY:
- PROBLEMS WITH EXPRESSING SELF OR UNDERSTANDING INSTRUCTIONS (IQ CONCERN):

MENTAL HEALTH NEEDS AND TREATMENT DISPOSITION

☐ No current mental health problems / No mental health history / Approved for general population housing.

☐ No current mental health problems / Reports mental health history / Approved for general population housing.

☐ ctive mental disorder symptoms / Refer to qualified mental health staff, **ASAP**.

☐ cutely suicidal, homicidal or psychotic / **Emergency** referral to qualified mental health staff.

ENED BY	DATE	TIME ☐ A.M. ☐ P.M.
REVIEWED BY QUALIFIED MENTAL HEALTH PROFESSIONAL	DATE	TIME ☐ A.M. ☐ P.M.

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-33 Transfer Screening (Essential) **Effective Date: October 15, 1999**

Ralf J. Salke
CMS Regional Manager

Gary H. Campbell, D.O.
CMS Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

R. Dale Riley, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure ensures that upon each transfer, a screening of the offender's health history is completed to assure continuity of care between institutions.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Transfers:** includes intrasystem, court outcounts, or any other time, the offender is required to leave the facility other than to work.

III. **PROCEDURES:**

A. Classification staff should notify the health services administrator of pending routine transfers at least 48 hours prior to the actual transfer.

1. Less notification may be necessary in cases of emergency transfers.

B. Upon notification of pending transfer, the health services administrator/designee shall determine whether any medical contraindications may interfere with normal transfer procedures.

1. Medical contraindications may include but are not limited to:

a. offender requires special transportation accommodations (i.e., ambulance, has airborne illness, etc.).
b. offender is currently housed in the facility's infirmary; or

c. offender is currently undergoing treatment for a serious medical need.

2. If medical contraindications are present, the medical director shall evaluate the offender to determine if transfer is safe and/or medically appropriate.

3. In cases where transfer is determined not to be appropriate and/or safe, the superintendent/designee and classification officer shall be notified and a medical hold initiated.

a. If an over-riding security issue exists that requires transfer, the regional medical director shall be notified prior to transfer.

C. Prior to transfer, the offender's medical record shall be screened and a Transfer-Receiving Screening (Attachment A) initiated.

D. The health services administrator of the sending institution shall notify the health services administrator of the receiving institution of any offenders requiring follow-up care or special accommodations.

E. An appropriate supply of medications shall be sent with the offender.

F. Upon arrival at the receiving institution, a face to face interview shall be conducted with the offender, by a licensed nurse, within twelve (12) hours of arrival and the receiving portion of the Transfer-Receiving Screening (Attachment A) completed.

G. There must be a sign in the intake area instructing offenders how to access care for immediate health needs.

H. Any pending appointments or diagnostic work-ups shall be initiated at the time of the screening.

I. Any medications shall be continued and/or reordered at the time of the screening.

J. The problem list shall be reviewed and updated.

K. If the offender was enrolled in any Chronic Care Clinic, they shall be scheduled to see the physician within 30 days of arrival to determine continued need of clinic and to review current treatment plan.

IV. ATTACHMENTS:

A. 931-3863 Transfer/Receiving Screening - Medical

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 1997. P-33.

VI. HISTORY: A. Original Effective Date: October 15, 1999

B. Revised Effective Date:

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

TRANSFER/RECEIVING SCREENING – MEDICAL

Transferring Institution

Inmate Name	DOC Number	Date	Time ☐ A.M. ☐ P.M.

...e W H Other	Age	Gender ☐ M ☐ F	Date of Birth	Food Handling Approved ☐ Yes ☐ No

...rgies

Current acute conditions/problems

Current conditions/problems

Current medications - name, dosage, frequency, duration

Acute short-term medications

Chronic long-term medications

Chronic psychotropic medications

Current treatments

Follow-up care needed

Last ppd	Results-MM	If positive – treatment dates	Date of last physical	M-score	Duty status

Chronic clinics	Specialty referrals

Significant medical history

...cal disabilities/limitations	Assistive devices/prosthetics	Glasses	Contacts

Mental health history/concerns

Substance abuse ☐ Yes ☐ No **Alcohol** ☐ Yes ☐ No **Drugs** ☐ Yes ☐ No

☐ HX suicide attempt ☐ HX psychotropic medication ☐ Previous psychiatric hospitalizations

Signature	Title	Date

TRANSFER RECEPTION SCREENING | DATE | TIME ☐ A.M. ☐ PM | Receiving Institution

S.O.A.P. FORMAT

S. Current complaint _____

Current medications/treatment _____

O. Physical appearance/behavior _____

...eformities: acute/chronic _____

_____ P _____ R _____ B/P _____ / _____

A. _____

P. Disposition (instructions: check or circle as appropriate)

- ☐ Routine sick call – instructions given
- ☐ Emergency referral
- ☐ HIV/TB instruction given
- ☐ Physician referral ☐ urgent ☐ routine
- ☐ Medication evaluation
- ☐ Work/program limitation
- ☐ Special housing
- ☐ Specialty referrals
- ☐ Chronic clinics
- ☐ Other
- ☐ Infirmary placement

Other _____

Signature and title

****

MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-32 **Receiving Screening – Intake Unit (Essential)**

Effective Date: October 15, 1999

Ralf J. Salke
CMS Regional Manager

Gary H. Campbell, D.O.
CMS Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

R. Dale Riley, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure ensures newly arrived offenders are screened to provide continuity of care and to identify offenders who pose a threat to their own or others' health or safety and who may require immediate intervention.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

None

III. **PROCEDURES:**

A. Medical Procedures:

1. Mantoux Tuberculin Skin Test (PPD) should be performed using Tubersol, according to IS11-14.2 Tuberculosis Control.

2. Following screening, the offender should be housed in the reception and orientation unit or designated area until the test results are reviewed and a physical assessment is completed not to exceed seven (7) days.

3. Medical staff conducting the receiving screening should inform the offender how to access health care services and the process to register complaints. Offenders will receive the information verbally and in writing.

B. General Procedures:

1. The receiving screening should be initiated by health care staff using the Intake Health Screening Form (Attachment A).

2. The Intake Mental Health Screening Form (Attachment B) should also be completed by health care staff with the copy sent to the institutional psychologist. The original should be placed in the offender's medical record.

   a. after review, the institutional psychologist shall assign a disposition for the offender and sign the copy of the Intake Mental Health Screening.

   b. after completion, the copy of the Intake Mental Health Screening shall be filed with the original in the offender's medical record.

3. If an offender's medical or mental health condition precludes placement in the designated area, the classification staff should be notified immediately.

4. Health care personnel should make special housing unit recommendations to the classification staff by memorandum or telephone followed by a memorandum.

5. Health care staff should schedule the offender for a physical assessment.

6. If the screening identifies a need for immediate mental health intervention, a recommendation should be made to the institutional psychologist in writing or verbally followed by a memorandum.

7. If the screening identifies the need for immediate medical intervention, this should be scheduled as soon as possible.

8. Offenders in need of non-emergency mental health assistance should be referred using the Psychological Evaluation Referral form (Attachment C) (Confidential).

9. Any offender who is unconscious, semi-conscious, bleeding, or otherwise obviously in need of immediate medical attention should be referred to the emergency room for care.

10. The reception center should initiate the offender's medical record.

11. The reception center physician shall complete the Initial Classification Assessment-Medical (ICA) (Attachment D) and the Lay-In/Medical/Duty Restrictions (Attachment E).

C. Findings of the screening should be recorded utilizing the MARS System. The screening should include:

1. current illness, health problems, significant family medical history, venereal diseases, other infectious diseases, and those health problems known to be specific to women or specific to ethnic groups.

2. mental health problems, suicidal history or potential.

3. medications taken, allergies, and specific health requirements (including dietary).

4. use of alcohol and other drugs to include the type of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of problems which may have occurred after ceasing use (i.e., convulsions, withdrawal).

5. dental problems.

D. The receiving screening should also include observation of:

1. behavior, which includes state of consciousness, mental status, appearance, conduct, tremors, and sweating.

2. body deformities, ease of movement, etc.

3. condition of skin, including trauma marking, bruises, jaundice, rashes, and infestations and needle marks or other indication of drug abuse.

4. persistent cough, lethargy, or other signs of tuberculosis.

IV. ATTACHMENTS

A.	931-3756	Intake Health Screening
B.	931-3757	Intake Mental Health Screening
C.	931-1572	Psychological Evaluation Referral
D.	931-0354	Initial Classification Analysis-Medical
E.	931-4061	Lay-In/Medical/Duty Restrictions

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 1997. P-32.

B. IS11-14.2 Tuberculosis Control

VI. HISTORY:

This policy was originally covered by IS11-31.1, located in the Missouri Department of Corrections Institutional Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INTAKE HEALTH SCREENING

NAME	DOC NUMBER	RACE	DATE OF BIRTH

ATE QUESTIONNAIRE	(CIRCLE ONE)	
DO YOU HAVE A MEDICAL PROBLEM SUCH AS BLEEDING OR INJURIES THAT REQUIRES IMMEDIATE MEDICAL ATTENTION?	YES	NO
2. ARE YOU CARRYING ANY MEDICATIONS OR TAKING MEDICATION CURRENTLY? _____	YES	NO
3. ARE YOU ALLERGIC TO ANY MEDICATIONS? _____	YES	NO
4. DO YOU HAVE ANY ALLERGIES? _____	YES	NO
5. HAVE YOU BEEN IN A HOSPITAL OR EMERGENCY ROOM IN THE PAST 6 MONTHS?	YES	NO
6. HAVE YOU FAINTED OR HAD A HEAD INJURY WITHIN PAST 6 MONTHS?	YES	NO
7. HAVE YOU BEEN TO A DOCTOR IN THE PAST 6 MONTHS?	YES	NO
8. ARE YOU ON A SPECIAL DIET?	YES	NO
9. DO YOU WEAR DENTURES OR PARTIAL PLATES?	YES	NO
10. DO YOU WEAR GLASSES OR CONTACT LENSES?	YES	NO
11. DO YOU HAVE A PROSTHESIS, SPLINT, CRUTCHES, CAST OR BRACE THAT YOU NEED WHILE HERE?	YES	NO
O YOU HAVE A CONTAGIOUS OR COMMUNICABLE DISEASE?	YES	NO
DO YOU HAVE PROBLEMS WITH CHRONIC COUGH, DIARRHEA OR HEART CONDITION?	YES	NO
14. DO YOU HAVE ANY ACUTE DENTAL PROBLEMS?	YES	NO
15. DO YOU HAVE ANY MEDICAL PROBLEMS WE SHOULD KNOW ABOUT?	YES	NO
16. ARE YOU COVERED BY MEDICAL INSURANCE OR BENEFITS PROGRAM?	YES	NO
17. HAVE YOU BEEN IN THIS FACILITY BEFORE?	YES	NO

SCREENER'S OBSERVATIONS	(CIRCLE ONE)	
1. IS INMATE UNCONSCIOUS?	YES	NO
2. DOES INMATE HAVE OBVIOUS PAIN, BLEEDING, INJURIES, ILLNESS OR OTHER SYMPTOMS SUGGESTING NEED FOR EMERGENCY MEDICAL REFERRAL?	YES	NO
3. DOES INMATE HAVE AN ARREST INJURY?	YES	NO
4. IS THERE OBVIOUS FEVER, SWOLLEN GLANDS, JAUNDICE, OR OTHER EVIDENCE OF INFECTION?	YES	NO
5. IS THERE EVIDENCE OF BODY VERMIN OR INFESTATION?	YES	NO
6. IS THERE EVIDENCE OF A SKIN RASH?	YES	NO
7. IS THERE EVIDENCE OF A CHRONIC COUGH?	YES	NO
8. ARE THERE SIGNS OF NEEDLE MARKS OR INDICATIONS OF DRUG ABUSE?	YES	NO
9. DOES THE INMATE HAVE A PHYSICAL HANDICAP OR SHOW EVIDENCE OF RESTRICTED MOBILITY?	YES	NO
10. DATE OF LAST TETANUS _____		
COMMENTS: _____		

FEMALE INMATES ONLY

1. ARE YOU PREGNANT?	YES	NO
2. ARE YOU ON BIRTH CONTROL PILLS?	YES	NO
3. HAVE YOU RECENTLY DELIVERED, HAD A MISCARRIAGE OR ABORTION?	YES	NO

SUMMARY/DISPOSITION

- ☐ ORIENTATION TO MEDICAL UNIT/SERVICES
- ☐ TRANSFER TO EMERGENCY ROOM FOR ACUTE MEDICAL PROBLEM
- ☐ REFERRAL FOR IMMEDIATE MEDICAL EVALUATION
- ☐ SCREENING INCOMPLETE DUE TO INMATE'S MENTAL STATUS
- ☐ INMATE REFUSED TO COOPERATE WITH SCREENING
- ☐ REFERRAL FOR ROUTINE MEDICAL EVALUATION
- ☐ CURRENTLY ON MEDICATION
- ☐ NON-EMERGENCY MEDICAL PROBLEM
- ☐ NO MEDICAL PROBLEMS IDENTIFIED OR REPORTED

SCREENED BY	DATE	TIME
RECEIVED BY	**DATE**	**TIME**

(MO) 931-2756 (7-94)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INTAKE MENTAL HEALTH SCREENING

ENDER NAME

	DOC NUMBER	RACE	DATE OF BIRTH

SUICIDE POTENTIAL SCREENING	(CIRCLE)	
1. ARRESTING OR TRANSPORTING OFFICER BELIEVES SUBJECT MAY BE SUICIDE RISK	YES	NO
2. LACKS CLOSE FAMILY/FRIENDS IN COMMUNITY	YES	NO
3. EXPERIENCED A SIGNIFICANT LOSS WITHIN LAST 6 MONTHS (LOSS OF JOB, RELATIONSHIP, DEATH OF CLOSE FAMILY MEMBER).	YES	NO
4. WORRIED ABOUT MAJOR PROBLEMS OTHER THAN LEGAL SITUATION (TERMINAL ILLNESS).	YES	NO
5. EXPRESSES THOUGHTS ABOUT KILLING SELF.	YES	NO
6. HAD A SUICIDE PLAN AND/OR SUICIDE INSTRUMENT IN POSSESSION.	YES	NO
7. HAD PREVIOUS SUICIDE ATTEMPT. (CHECK WRISTS & NOTE METHOD).	YES	NO
8. EXPRESSES FEELINGS THAT THERE IS NOTHING TO LOOK FORWARD TO IN THE FUTURE (FEELINGS OF HELPLESSNESS AND HOPELESSNESS).	YES	NO
9. SHOWS SIGNS OF DEPRESSION (CRYING, EMOTIONAL FLATNESS).	YES	NO
10. APPEARS OVERLY ANXIOUS, AFRAID OR ANGRY.	YES	NO
11. APPEARS TO FEEL UNUSUALLY EMBARRASSED OR ASHAMED.	YES	NO
12. IS ACTING AND/OR TALKING IN A STRANGE MANNER. (CANNOT FOCUS ATTENTION; HEARING OR SEEING THINGS NOT THERE).	YES	NO
S APPARENTLY UNDER THE INFLUENCE OF ALCOHOL OR DRUGS.	YES	NO
1. IF YES TO #13, IS INDIVIDUAL INCOHERENT OR SHOWING SIGNS OF WITHDRAWAL OR MENTAL ILLNESS.	YES	NO
TOTAL YES'S = IF THERE ARE ANY CIRCLES IN SHADED AREAS, OR TOTAL OF YES'S IS 6 OR MORE, ALERT SHIFT SUPERVISOR AND REFER FOR MENTAL HEALTH EVALUATION.		

MENTAL HEALTH HISTORY	(CIRCLE)	
1. NOW TAKING PSYCHOTROPIC MEDICATION? TYPE: CURRENT DOSAGE: SOURCE:	YES	NO
2. HISTORY OF PSYCHIATRIC HOSPITALIZATION? WHEN: WHERE:	YES	NO
3. HISTORY OF OUTPATIENT MENTAL HEALTH TREATMENT? WHEN: WHERE:	YES	NO

MENTAL HEALTH HISTORY (CON'T)	(CIRCLE)	
4. HISTORY OF VIOLENCE OR ASSAULT TO CAUSE INJURY ONLY? WHEN:	YES	NO
5. HISTORY OF SEX OFFENDING? WHEN:	YES	NO
6. HISTORY OF BEING SEXUALLY VICTIMIZED? WHEN: WHERE:	YES	NO
7. HISTORY OF SERIOUS HEAD TRAUMA WITH LOC AND/OR SEIZURES? WHEN:	YES	NO

BEHAVIORAL OBSERVATIONS
CIRCLE AND COMMENT ON ANY PROBLEMS IN THE FOLLOWING AREAS:

- GROOMING & HYGIENE:
- MOTOR ACTIVITY:
- ATTENTION & CON:
- ORIENTATION (PERSON/PLACE/TIME/SITUATION):
- SPEECH RATE:
- UNUSUAL SPEECH CONTENT (HALLUCINATIONS, DELUSIONAL IDEAS):
- MOOD & EMOTIONALITY:
- PROBLEMS WITH EXPRESSING SELF OR UNDERSTANDING INSTRUCTIONS (IQ CONCERN):

MENTAL HEALTH NEEDS AND TREATMENT DISPOSITION

☐ No current mental health problems / No mental health history / Approved for general population housing.

☐ No current mental health problems / Reports mental health history / Approved for general population housing.

:tive mental disorder symptoms / Refer to qualified mental health staff, **ASAP.**

Acutely suicidal, homicidal or psychotic / **Emergency** referral to qualified mental health staff.

SC) BY

REVIEWED BY QUALIFIED MENTAL HEALTH PROFESSIONAL	DATE	TIME
		☐ A.M. ☐ P.M.
	DATE	TIME
		☐ A.M. ☐ P.M.

O 931-3757 (9-99)

DISTRIBUTION: WHITE - MEDICAL FILE CANARY - MENTAL HEALTH UNIT

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

PSYCHOLOGICAL EVALUATION REFERRAL (CONFIDENTIAL)

NAME	NAME OF INSTITUTION	HOUSING UNIT
	REGISTER NUMBER	DATE

REASON FOR REFERRAL: DESCRIBE BRIEFLY YOUR REASON FOR MAKING THIS REFERRAL (INCLUDE A DESCRIPTION OF OBSERVABLE BEHAVIORS ETC ATTACH I.O.C. IF NECESSARY).

REFERRING STAFF SIGNATURE

SUBMIT THIS FORM TO PSYCHOLOGIST

BELOW TO BE FILLED OUT BY PSYCHOLOGIST

ASSESSMENT/SESSION INFORMATION

RECOMMENDATIONS & SUMMARY

PSYCHOLOGIST SIGNATURE

DATE

1931 1572 (5-89)

DISTRIBUTION: WHITE-MEDICAL CHART CANARY-PSYCHOLOGIST PINK-CLASSIFICATION FILE

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INITIAL CLASSIFICATION ANALYSIS (ICA) MEDICAL NEEDS (M)

ATE NAME	DOC NUMBER	DATE

ructions: Circle appropriate level and enter M score. Also check R for restriction or U for unrestricted. If an R is listed, please complete the restrictions section so the most appropriate assignment can be made.

M-5 CHRONIC CARE NEEDED

PCC MCC JCCC FCC FRDC WMCC

- 24 hour level one infirmary
- Controlled medications necessary
- Unstable diabetic

_____ (R) Restricted - Physical or transfer restrictions apply. Investigate prior to transfer (see Restrictions/Special Needs below)
_____ (U) Unrestricted - No physical or transfer restrictions apply.

M-4 LIMITED INFIRMARY SUPERVISION REQUIRED

MECC RCC CCC

- 24-hour nursing staff availability
- 24-hour level two observation availability
- Unstable seizure disorder or noncompliant with medications
- Unstable COPD or noncompliant with treatment
- Unstable CAD or noncompliant with treatment
- Controlled medications necessary

_____ (R) Restricted - Physical or transfer restrictions apply. Investigate prior to transfer (see Restrictions/Special Needs below)
_____ (U) Unrestricted - No physical or transfer restrictions apply.

CLINIC SUPERVISION REQUIRED

ACC CMCC BCC

- 24-hour clinic availability indicated
- Stable insulin dependent diabetic for 6 months
- Seizure free for 6 months
- Stable COPD for 6 months - no hospitalizations
- Stable CAD for 6 months - no hospitalizations
- Controlled medications necessary
- Stable asthma for 6 months - no hospitalizations

_____ (R) Restricted - Physical or transfer restrictions apply. Investigate prior to transfer (see Restrictions/Special Needs below)
_____ (U) Unrestricted - No physical or transfer restrictions apply.

M-2 ROUTINE SICK CALL

OCC TTC SLCRC KCCRC RF ITCS

- Stable insulin dependent diabetic for 1 year
- Seizure free for 1 year
- Stable COPD - no hospitalizations for 1 year
- Stable CAD - no hospitalizations for 1 year
- On no controlled medications (Exception - One dose per day of Phenobarb or Klonopin for seizure disorder)
- No EDC within five months of arrival to DOC

_____ (R) Restricted - Physical or transfer restrictions apply. Investigate prior to transfer (see Restrictions/Special Needs below)
_____ (U) Unrestricted - No physical or transfer restrictions apply.

IONE

- No physical ailments or medical difficulties

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

LAY-IN/MEDICAL/DUTY RESTRICTIONS

OFFENDER NAME	DOC NUMBER	INSTITUTION
		DATE
CURRENT ASSIGNMENT		HOUSING UNIT

☐ FULL DUTY - No Restrictions - May Work In Food Service/Food Handling

☐	LIMITED DUTY OR MEDICAL RESTRICTION (Must Check Restrictions)	Permanent	Limited To (Date)	Able to Attend School, MOSOP Substance Abuse Classes	Able to Attend Work Activities
☐	Nonsmoking Roommate			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Prolonged Standing Assignments			☐ YES ☐ NO	☐ YES ☐ NO
☐	Lifting Restrictions of _____ Pounds			☐ YES ☐ NO	☐ YES ☐ NO
☐	No High Places or Use of Ladders			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Use of Chainsaws or Other Sharp Objects			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Snow Shoveling			☐ YES ☐ NO	☐ YES ☐ NO
☐	☐ No or ☐ Limited Exposure to Cold			☐ YES ☐ NO	☐ YES ☐ NO
☐	Requires Lower Bunk			☐ YES ☐ NO	☐ YES ☐ NO
☐	Requires Lower Floor			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Recreational Activities			☐ YES ☐ NO	☐ YES ☐ NO
☐	Can Work In Food Service But Cannot Handle Food			☐ YES ☐ NO	☐ YES ☐ NO
☐	Other			☐ YES ☐ NO	☐ YES ☐ NO

MEDICALLY UNASSIGNED (Must Check One) Inmate is restricted to housing unit unless authorized for release to specific activities.

☐	Lay-In (Temporary Less Than 48 Hours)	End Date
	NURSE SIGNATURE	
☐	Permanent	
☐	Lay-In (Temporary Over 48 Hours)	End Date
	PHYSICIAN SIGNATURE	

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

****

IS11-31 **Information on Health Services (Essential)** **Effective Date: October 15, 1999**

Ralf J. Salke
Regional Manager

Gary H. Campbell, DO
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

R. Dale Riley, Director
Division of Offender
Rehabilitation Services

****

I. **PURPOSE:** This procedure ensures offenders receive information concerning access to medical, dental, and mental health care in a manner that is understandable to them.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

None

III. **PROCEDURES:**

A. Health care screening staff should instruct newly arrived offenders at the time of receiving screening on how to access health care services and obtain medication.

1. The information should be verbally and in writing, in a form understandable by the offender.

2. The information should also be posted in the receiving area and in the housing units in a common area for all offenders.

B. Information concerning health services available should be provided to the offender in the written institutional orientation packet per standard operating procedure.

C. The health services administrator should review access to health care information in the institutional orientation packet at least annually to assure accuracy of information and update information as changes are made.

D. If the offender is unable to understand access to care information due to language difficulties, illiteracy, deafness, developmental disability, or mental illness, health care staff should request assistance.

1. Each facility should develop a standard operating procedure on how assistance is requested for these individuals.

IV. ATTACHMENTS:

None

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 1997. P-31

VI. HISTORY: Formerly covered under IS11-32.1 in the Missouri Department of Corrections Institutional Policy and Procedure Manual. Original Effective Rule: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

MATT BLUNT
Governor

LARRY CRAWFORD
Director

Regional Manager
CMS

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TDD Available

State of Missouri
DEPARTMENT OF CORRECTIONS
Ad Excelleum Conamur - "We Strive Towards Excellence"

OFFICE OF INSPECTOR GENERAL

Compliance Unit **M e m o r a n d u m**

DATE: April 14, 2005

TO: Institutional Services Policy & Procedure Manual Holders

FROM: Sheila A. Scott, Administrative Analyst III

SUBJECT: **IS11-30 Hospital and Specialized Ambulatory Care**

Attached is IS11-30 Hospital and Specialized Ambulatory Care which goes into effect on April 29, 2005.

Please review this procedure and place appropriately in your manual.

Thank you.

SAS:vf

****

MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

****

IS11-30 Hospital and Specialized Ambulatory Care

Effective Date: April 29, 2005

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, DO
Regional Medical Director

Steve Long, Acting Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitation Services

****

I. PURPOSE: This procedure has been developed to insure emergency room and acute hospitalization should be provided at a community hospital when such care cannot be provided on-site. The Missouri Department of Corrections and Correctional Medical Services shall provide offenders with access to secondary and tertiary care.

A. **AUTHORITY:** 217.075, 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Specialty Care:** Specialist-provided health care (e.g., nephrology, surgery, dermatology, and orthopedic).

B. **Written Agreement:** A contract or letter of agreement, or memorandum of understanding between the facility and the hospital, clinic, or specialist for the care and treatment of offender patients.

III. PROCEDURES:

A. Correctional Medical Services should obtain written agreements with accredited hospitals and health care providers that meet state licensure requirements.

B. Offenders should be referred to these facilities when specialized medical, mental health, or dental services are required that are beyond the capability of the on-site health care system.

C. The Emergency Room Log (Attachment A) should be completed by the health services admnistrator/designee at the time of referral when an offender is sent to the emergency room.

D. The Off-site Referral Log (Attachment B) should be maintained to document physician referral to off-site outpatient care and or inpatient hospitalization.

E. Medical staff should contact the chief of custody to facilitate transportation to the off-site provider.

F. The health services administrator/designee should ensure health information necessary for treatment or consultation is made available to the specialty provider.

G. The health service administrator/designee ensures a summary of treatment, evaluation, and or consultation report is received and recorded in the off-site specialists medical accountability record system with the hard copy placed in the offender hard copy medical record.

H. The responsible physician should review all off-site specialty service recommendations and/or consult summary information with documentation and follow-up as indicated.

I. The responsible physician and heatlh services administrator/designee will ensure appointments are scheduled in accordance with the level of need.

J. The health services administrator/designee will monitor the scheduling of appointments at least weekly.

IV. ATTACHMENTS:

A. 931-3810 Emergency Room Log
B. 931-4175 Off-site Referral Log

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 2003, P-D-05 Hospital and Specialty Care – *important.*
B. IS11-42 Patient Transport
C. IS11-44.1 Medical Continuity of Care

VI. HISTORY: Formerly covered under IS11-29 Hospital And Specialized Ambulatory Care and IS11-29.1 Hospital and Specialized Ambulatory Care procedure in the Missouri Department of Corrections Institutional Services Policy and Procedure Manual. Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: April 29, 2005

ATTACHMENT A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

EMERGENCY ROOM LOG

INSTITUTION	MONTH AND YEAR

DATE	NAME	DOC NUMBER/ DOB	HOSPITAL	TRANSPORT	DIAGNOSIS	DISPOSITION

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

ATTACHMENT B

OFF-SITE REFERRAL LOG

OFFENDER NAME	DOC NUMBER	ORDER DATE	PHYSICIAN	REASON	DATE CONSULT FORM APPROVED	DATE SCHEDULED	DATE CANCEL/ REASON	DATE RESCHED-ULED	DATE COMPLETED	FOLLOW UP REQUESTED

MO 931-4175 (2-99

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

****

IS11-30.1 **Transfer to Acute Psychiatric Inpatient Treatment** **Effective Date: August 25, 2003**

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, DO
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

Randee Kaiser, Director
Division of Offender
Rehabilitation Services

****

I. **PURPOSE:** This procedure is to facilitate timely transfer to an inpatient psychiatric facility ensuring continuity of care for offenders requiring more intensive inpatient psychiatric treatment than can be provided at the correctional institution.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C: **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A: **Acute Psychiatric Transfer:** Transfer to an acute inpatient psychiatric setting whenever the offender presents a danger to self or others due to acute psychosis or other psychiatric difficulties which cannot be treated effectively within the institution. Involuntary transfer of these offenders should be completed taking into consideration existing procedures. See policy IS12-3.1, Biggs Correctional Treatment Unit for transfer procedures.

III. **PROCEDURES:**

A. Offenders appropriate for referrals for psychiatric evaluation are the following:

1. acutely psychotic, presenting imminent risk to self/others and refusing treatment.

2. suicidal and refusing treatment.

3. psychotic and/or experiencing significant psychological distress, complying with treatment recommendations, but not demonstrating adequate symptom relief.

B. Referral of offender for acute inpatient psychiatric evaluation and treatment should be made in compliance to IS12-3.1, Biggs Correctional Treatment Unit.

IV. ATTACHMENTS:

None

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 2003, P-G-04 Mental Health Services – *essential,* P-E-12 Continuity of Care During Incarceration – *essential,* P-D-05 Hospital and Specialty Care – *important.*
B. IS12-3.1 Biggs Correctional Treatment Unit.
C. IS11-30 Hospital and Specialized Ambulatory Care

VI. HISTORY: Formerly covered under IS 11-29.2 of the Missouri Department of Corrections Institutional Policy and Procedure Manual. Original Rule Effective: August 15, 1998.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date:

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURES MANUAL

****

IS11-40 **Direct Orders (Essential)** **Effective Date: October 15, 1999**

Ralf J. Salke
Regional Manager

Gary H. Campbell, D.O.
Regional Medical Director

George A Lombardi, Director
Division of
Adult Institutions

R. Dale Riley, Director
Division of Offender
Rehabilitation Services

****

I. **Purpose:** This procedure ensures treatment performed by qualified health care personnel other than physicians or dentists is pursuant to written or verbal orders signed by personnel authorized by law to give such orders.

A. **AUTHORITY:** 217.040, 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 1997

B. **APPLICABILITY:** Standard Operating Procedure (SOP) specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional medical providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **MARS:** Medical Accountability Record System

III. **PROCEDURES:**

A. All medical orders should be documented in the Medical Accountability Records System (MARS).

B. Medical orders should be communicated appropriately to assure implementation.

C. Only physicians, dentists, and other authorized individuals should prescribe medical orders for offenders of the institution.

D. Verbal and/or telephone orders should be documented as such in the MARS and signed by the physician or dentist during their next visit.

E. Medical/dental recommendations from outside providers should be reviewed by the medical director or chief dentist before initiation by the health care staff. Upon approval these recommendations should be transcribed into the Medical Records Accountability Records System with a notation indicating which authority approved the recommendations.

F. Direct orders, recorded in the MARS system, shall be noted by qualified health care staff by printing orders. The qualified health care staff shall check each order as it is completed/initiated and shall date, time, and sign the orders. The orders shall be placed in a hard copy record.

1. This procedure for signing off direct orders are in effect until such a time as electronically signing off orders is available.

IV. ATTACHMENTS:

None

V. REFERENCES:

A. National Commission of Correctional Health Care: Standards for Health Services in Prisons, 1997. P-40

VI. HISTORY: This policy was originally covered by IS11-39, located in the Missouri Department of Corrections Institutional Policy and Procedure Manual; Original Effective Date: August 15, 1994

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999